

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Revocation of  
the Family Child Care License of  
Judy Marquardt

**FINDINGS OF FACT,  
CONCLUSIONS,  
AND RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Beverly Jones Heydinger at 10:00 a.m. on October 13, 2004, at the Olmsted County Attorney's Office, Olmsted County Government Center, 151 Fourth Street S.E., Rochester, MN 55904. Geoffrey A. Hjerleid, Senior Assistant Olmsted County Attorney, 151 Fourth Street S.E., Rochester, MN 55904-3710, appeared on behalf of the Department of Human Services (DHS or Department). Mark G. Stephenson, Attorney at Law, Stephenson & Sutcliffe, P.A., 1635 Greenview Drive S.W., Rochester, Minnesota 55902, appeared on behalf of Judy Marquardt, the Licensee. After receiving an addendum to the exhibits, the hearing concluded with closing arguments conducted by telephone conference on October 19, 2004. The hearing record closed on October 19, 2004.

**THESE FINDINGS OF FACT, CONCLUSIONS AND RECOMMENDATIONS  
ARE PUBLIC, BUT THE RECORD ON WHICH THEY ARE BASED CONTAINS  
INFORMATION THAT IS NOT PUBLIC.**

**NOTICE**

This report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record and may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendation. Under Minn. Stat. § 14.61 (2002), the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact Kevin Goodno, Commissioner, Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

## **STATEMENT OF ISSUES**

Has the Licensee repeatedly failed to adequately supervise the children within her care, failed to report a serious injury to a child in her daycare, and violated the useable space and equipment rules governing daycare?

Based upon all of the proceedings herein, the Administrative Law Judge makes the following:

## **FINDINGS OF FACT**

1. The Licensee, Judy Marquardt, is licensed by DHS to provide family child care at her home at 2737 Tomah Place N.W., Rochester, Minnesota. She has been licensed since 1995. The Licensee holds a C-2 group family child care license.<sup>[1]</sup> Under that license, she may care for up to ten children under school age, with no more than two being infants or toddlers. With a helper, the maximum in care is twelve children.

2. The County conducted a relicensing visit on March 21, 2000. During that visit a number of items were identified as needing correction. These items included the need for an effective child gate, the absence of an inspection tag for the fire extinguisher, the temperature of the hot water was too high, and a plant (philodendron) on the County's list was accessible to daycare children. The County issued a correction order regarding these items.<sup>[2]</sup>

3. On March 30, 2000, the Licensee was conducting her daycare with an additional child, A.J. who was approximately two years old. The daycare children were outside playing hide and seek. The Licensee entered the residence to change a diaper and came back out. A.J. could not be found at that time. The Licensee began searching for A.J. on the daycare premises. A.J. had wandered out of the Licensee's yard and was found by a neighbor nearby. The yard was not fenced.<sup>[3]</sup> The neighbor arrived with A.J. just before the Licensee was to contact 911.<sup>[4]</sup> Olmsted County Social Services investigated and concluded that the Licensee was not responsible for neglecting A.J. under the circumstances.<sup>[5]</sup>

4. Olmsted County Community Services (County) recommended to the Department that the Licensee be placed on conditional licensure for one year due to the wandering incident.<sup>[6]</sup> On December 7, 2000, the Department issued its Order placing the Licensee's daycare license on conditional status for one year.<sup>[7]</sup> The reasons given for imposing the conditional status included the items listed in the March 21, 2000 correction order and the incident regarding A.J.'s supervision.

5. After the conditional period expired, the Licensee received a variance to use a mesh-sided portable crib.<sup>[8]</sup> This equipment was used for the younger children in the daycare for naps.

6. On July 30, 2001, the County inspector visited the daycare premises and noticed children playing outside the house. The inspector did not observe the Licensee

with the children. The inspector rang the front door bell and the Licensee came to the door, holding a young child. The Licensee did not open the door, but went out the back and came around front to meet the inspector.<sup>[9]</sup>

7. On March 14, 2002, the County conducted a relicensing visit of the daycare premises. Three items (smoke detector, radio batteries, and hand towels) were noted for correction. The County inspector noted that the Licensee did not immediately hear a child crying on another floor of the premises. The County recommended that the license be reissued.<sup>[10]</sup>

8. The Licensee moved into a different residence in March 2003. The County conducted an off-year licensing visit to the new premises on March 31, 2003. The County inspector noted that some electrical outlets were not covered, a new daycare contract item had not been signed by parents, and that gates were required at both the top and bottom of stairs that were accessible to children younger than 18 months.<sup>[11]</sup> A correction order was issued for these items and the deficiencies were corrected by the Licensee.<sup>[12]</sup> The correction order was issued even though the Licensee had not yet begun to care for children in the daycare premises.<sup>[13]</sup> No daycare children were exposed to any of the items identified in the visit. The Licensee informed the inspector that the kitchen, dining room, living room (all upstairs) and downstairs would be used for daycare.<sup>[14]</sup>

9. The downstairs area contains a playroom. The room was set up with toys, games, an easel, a play kitchen, a low table, and an age-appropriate computer with a chair.<sup>[15]</sup> The computer was encased in a "Little Tykes" stand, keeping the keyboard low to the ground.<sup>[16]</sup>

10. In late 2003, E.D. and Z.D. were in the Licensee's daycare. E.D. was a toddler (younger than 24 months) and Z.D. was four years old at that time. At some point during the day, E.D. tripped and fell on a storage bin, cutting her chin. The cut did not bleed significantly and the Licensee applied a bandage. Since the cut was not bleeding, the Licensee did not consider the cut to be serious. The Licensee informed E.D.'s parents when they arrived to pick up E.D. and Z.D. in the afternoon. E.D.'s parents indicated at the time that the cut was not serious and made no complaint that the Licensee had failed to contact them sooner. E.D.'s parents told the Licensee that the cut did not require E.D. to be seen by a physician.<sup>[17]</sup>

11. On January 15, 2004, E.D. and Z.D. were in the downstairs play area. E.D. was 18 months old at that time. As part of the normal routine, E.D. and Z.D. were playing with toys. The Licensee set up the child gate and went upstairs to see to other daycare children.<sup>[18]</sup> After a few minutes, the Licensee was returning to the play area. At approximately 9:15 a.m., while on the stairs leading down to the play area, the Licensee heard the sound of a fall and a child crying. The Licensee immediately responded to the incident, and found E.D. lying on the floor, between the computer and another large toy.<sup>[19]</sup> The Licensee picked up E.D. and comforted her, and E.D. stopped crying. E.D. showed no signs of injury at that time.<sup>[20]</sup> The Licensee inferred that E.D. had climbed up on the computer (or the stool) and fallen off.<sup>[21]</sup>

12. Later in the day, the Licensee put E.D. in a mesh-sided portable crib for a nap. The Licensee was aware that E.D. had climbed out of this crib before and she was listening for sounds that E.D. was climbing out. Twice, the Licensee heard the scrambling sound indicating that E.D. was climbing over the side of the crib. On each occasion, the Licensee went into the room and found that E.D. had climbed out of the crib. E.D. cried at the time, but showed no signs of injury at that time.<sup>[22]</sup> Each time, the Licensee lifted E.D. and placed her back in the crib. E.D. did not display any signs of pain on either occasion. The Licensee thought that E.D. was crying to stay out of the crib.<sup>[23]</sup> After being placed in the portable crib for the second time, E.D. napped for two hours.

13. On January 15, 2004, E.D. went up the stairs once after her nap using her arms and legs. On that occasion, E.D. did not display any sign of significant pain while going up the stairs. E.D. said "owie" once while climbing the stairs at that time (just before being picked up from the daycare).<sup>[24]</sup> The Licensee heard E.D. say this, but thought that E.D. had stepped or kneeled on a toy.<sup>[25]</sup>

14. E.D. and Z.D.'s father called to pick them up in the afternoon. As was her usual practice, the Licensee had E.D. and Z.D. in their coats when the parent arrived. The Licensee helped put on E.D.'s coat. E.D. did not display any signs of discomfort in putting on her coat.<sup>[26]</sup> E.D. had been "fussing" at that time, but there was no particular sign that she was injured. After a few minutes, the parent arrived. The Licensee and E.D.'s parent spoke for a few minutes before the parent, E.D. and Z.D. left the daycare. Neither adult noticed anything unusual at that time.<sup>[27]</sup>

15. The parent took E.D. and Z.D. to the car, and placed both of the children in carseats. E.D. did not show any signs of discomfort at that time. The parent gave E.D. a bath after arriving home. In the bath, E.D. cried and displayed pain centering on her elbow. After conferring with the other parent, E.D. was taken to the emergency room at St. Mary's Hospital. An x-ray showed that E.D. had suffered a fracture of her arm.<sup>[28]</sup> The hospital staff did not consider the injury to be a "suspicious/unexplained injury."<sup>[29]</sup> After being informed of the injury, a parent called the Licensee. The Licensee was surprised to hear that E.D. had suffered a fracture.<sup>[30]</sup>

16. A report was made to Olmsted County Social Services. Social Services conducted a child protection investigation, including a contact with the treating physician.<sup>[31]</sup> Social Services closed the case, indicating "no further action needed."<sup>[32]</sup> There was no determination of maltreatment by the Licensee.<sup>[33]</sup>

17. The County licensing staff conducted an independent investigation that included interviewing the Licensee, parents and four daycare children. Some of the children indicated that one child bit and pulled hair.<sup>[34]</sup> Others indicated that they sometimes ate on the floor in the kitchen. The children indicated that the Licensee sometimes left them in the playroom to play by themselves.

18. The Licensee acknowledged that a child in her daycare had engaged in biting and outlined the additional supervision that she provided to that child to eliminate

the behavior. The eating on the floor was described as having an indoor picnic and noted that this was a common activity in the daycare. Based on the interviews, the County issued a correction order on February 27, 2004, identifying a lack of supervision regarding E.D.'s fall and the biting child, failure to report E.D.'s injury, insufficient space in the playroom for the number of children in care and eating on the kitchen floor as violations needing correction.<sup>[35]</sup>

19. On March 25, 2004, the County licensing staff recommended to the Department of Human Services that the Licensee's family day care license be revoked for failing to supervise E.D. The recommendation also identified several instances of a child biting in the daycare, failure to report E.D.'s injury to the County, a prior injury to E.D.'s chin that was not reported, feeding children meals off of the kitchen floor, and insufficient square footage of the playroom as reasons for revoking her license.<sup>[36]</sup> The prior history of inspections and the conditional license were also offered in support of revocation.

20. On May 20, 2004, the Department issued an Order of Revocation.<sup>[37]</sup> The Order identified violations of the supervision rule and reporting rule as supporting the proposed revocation. The Order identified the injury to E.D., the biting incidents and the wandering incident in 2000 as the basis for the supervision violation. The failure to report violation was identified as the failure to report the injury to E.D. The Order also identified allegations of eating on the kitchen floor and the size of the playroom as violations of the indoor space standard.<sup>[38]</sup> The Licensee appealed the proposed revocation.<sup>[39]</sup>

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

## **CONCLUSIONS**

1. The Commissioner and the Administrative Law Judge have jurisdiction to consider revocation of the Licensee's license to provide family day care.<sup>[40]</sup>

2. The Department and Olmsted County have complied with all substantive and procedural requirements.

3. The Department has the burden of demonstrating reasonable cause for taking action against the Licensee. If reasonable cause exists, the burden shifts to the licensee to demonstrate by a preponderance of the evidence that the license holder was in full compliance with the laws or rules alleged to be violated.<sup>[41]</sup>

4. The Department's rules require that a caregiver adequately supervise the children in her care. " 'Supervision' means a caregiver being within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver is capable of intervening to protect the health and safety of the child."<sup>[42]</sup>

5. The Department has demonstrated that it had reasonable cause to take action against the Licensee.

6. The Licensee has shown by a preponderance of the evidence that there was adequate supervision of the children in her care on January 15, 2004. The Licensee has shown that she exercised adequate supervision of the children in her care when one of the daycare children engaged in biting behavior.

7. The Department's rules require that a caregiver report serious injuries to children in daycare. "Serious injuries" are those requiring treatment by physician.<sup>[43]</sup>

8. The Licensee has shown by a preponderance of the evidence that there was no indication of a serious injury occurring in her daycare that would trigger the reporting requirement of Minn. R. 9502.0375.

9. The Department's rules require that a caregiver provide appropriate equipment and adequate indoor space for the children in her care.<sup>[44]</sup>

10. The Licensee has shown by a preponderance of the evidence that there was appropriate equipment and adequate indoor space for the children in her daycare.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

### **RECOMMENDATION**

IT IS HEREBY RECOMMENDED:

1. That the Commissioner of Human Services not revoke Ms. Marquardt's child care license.
2. That the Protective Order remain in effect.

Dated this 18<sup>th</sup> day of November, 2004.

/s/ Beverly Jones Heydinger

BEVERLY JONES HEYDINGER  
Administrative Law Judge

Reported: Tape-recorded (8 tapes)

### **NOTICE**

Pursuant to Minn. Stat. § 14.62, subd. 1 (2002), the Commissioner is required to serve his final decision upon each party and the Administrative Law Judge by first class mail.

### **MEMORANDUM**

For the revocation of the Licensee's family day care license to be sustained, there must be some evidence that the Licensee was not providing supervision as called for in Minn. R. 9502.0315. The only evidence in the record of this proceeding is that the Licensee was within sight or hearing of the children at all times so that the caregiver is

capable of intervening to protect the health and safety of the children, which is the standard imposed by the rule. The rule does not require that all children in care be continually within the sight of the Licensee.

The particular fall relied upon by the County investigator as causing E.D.'s fracture was actually heard by the Licensee and she immediately responded. Assuming that this particular fall caused E.D.'s injury, there is no evidence in the record that suggests that her supervision was inadequate. The children were in a safe area, with furniture designed for children; nothing suggests that all children must be constantly in view. The standard suggested by the Department in this matter is much higher than the standard imposed by the rule.

In addition, it is not at all clear that the injury relied on by the Department to support a sanction occurred at the Licensee's daycare. E.D. showed no signs of injury, and her own actions after that particular fall would not have alerted the Licensee of the injury that was identified later that day. E.D. twice climbed out of a portable crib without showing signs of pain. E.D. climbed stairs using her arms and legs, without displaying significant impairment or signs of serious pain. The Licensee could reasonably conclude that E.D. did not suffer an injury from the particular fall, or the two subsequent efforts to climb out of a portable crib.

Since the Licensee was unaware that E.D. was injured, there is no violation of the rule governing reporting injuries. The Department's interpretation of the rule would require licensees to report any injury that might have happened at a daycare, even if the Licensee was unaware of that injury. Given these facts, the Licensee was not required to report that the injury occurred at the daycare. There was no violation of Minn. R. 9502.0375.

The Department also referred to the earlier incidents of biting by one daycare child as supporting a violation of the supervision standard. The Licensee described the specific actions taken to increase supervision of that child until the behavior was no longer occurring. The actions taken by the Licensee are consistent with the obligations of the supervision rule. The Licensee has met her burden to show that she was in compliance with the supervision rule.

At the hearing, the Department asserted that prior incidents, including the wandering incident in 2000 and an inspector's observation in 2001, support a finding that the Licensee violated the supervision rule. Those prior incidents would be appropriate to consider in arriving at a sanction, once a violation concerning supervision of E.D. had been demonstrated. In this matter, the evidence in the record shows that no violation of the supervision standard occurred. The Licensee's conditional status ended in 2001. The prior incidents do not demonstrate any violation of the applicable rules in 2004.

The County offered other instances of prior noncompliance relating to a philodendron and inspections of a fire extinguisher in support of revocation as an appropriate sanction. These instances were not included in the Notice of Hearing and there was insufficient evidence to conclude that these violations occurred. Regardless, they would be insufficient to support revocation.

The County approved the daycare premises. At the time of that approval, no concern was raised over the amount of indoor space of the daycare. The record lacks any evidence that the daycare premises do not meet the minimum requirement of 35 square feet of useable space per child.<sup>[45]</sup> The Licensee gave credible testimony that she used other areas in the home for quiet daycare activities, such as reading and drawing. The Licensee discussed her practice of “picnicking” with representatives of the County food program. Those representatives approved of the practice.<sup>[46]</sup> The Department can direct that the practice be discontinued, but the facts do not support finding a violation of the rules governing the Licensee’s daycare.

Under Minn. Stat. § 245A.08, subd. 3, the Licensee bears the burden of showing that she was in compliance with the rules governing her daycare. The record in this matter demonstrates that she has met that burden.

B.J.H.

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<sup>[1]</sup> Licensee Ex. 33.

<sup>[2]</sup> Dept. Ex. 6.

<sup>[3]</sup> Dept. Ex. 4.

<sup>[4]</sup> Licensee Ex. 27.

<sup>[5]</sup> Licensee Ex. 28.

<sup>[6]</sup> Dept. Ex. 5.

<sup>[7]</sup> Dept. Ex. 8.

<sup>[8]</sup> Licensee Ex. 20.

<sup>[9]</sup> Testimony of Keith Lewis, Tape 7.

<sup>[10]</sup> Licensee Ex. 18.

<sup>[11]</sup> Licensee Ex. 17.

<sup>[12]</sup> Licensee Ex. 16.

<sup>[13]</sup> Licensee Ex. 17.

<sup>[14]</sup> Licensee Ex. 17.

<sup>[15]</sup> Licensee Exs. 46 N-Q.

<sup>[16]</sup> The County points out that the computer was designated for children “3 and up.” This appears to relate to the operation of the computer, not the suitability of the furniture for use by toddlers.

<sup>[17]</sup> Testimony of Judy Marquardt, Tape 6.

<sup>[18]</sup> Testimony of Judy Marquardt, Tape 6.

<sup>[19]</sup> Testimony of Judy Marquardt, Tape 6.

<sup>[20]</sup> Testimony of Judy Marquardt, Tape 4.

<sup>[21]</sup> Testimony of Judy Marquardt, Tape 6.

<sup>[22]</sup> Licensee Ex. 24.

<sup>[23]</sup> Testimony of Judy Marquardt, Tape 6.

<sup>[24]</sup> Licensee Ex. 24.

<sup>[25]</sup> Testimony of Judy Marquardt, Tape 4.

<sup>[26]</sup> Testimony of Judy Marquardt, Tape 4.

<sup>[27]</sup> Testimony of Judy Marquardt, Tape 6.

<sup>[28]</sup> The record in this matter conflicts on where the injury was suffered. A number of documents indicate that the fracture was “above the elbow” (suggesting the humerus). A report received from a physician indicated that the fracture was located on the ulna (the forearm below the elbow).

<sup>[29]</sup> Dept. Ex. 11.

<sup>[30]</sup> Licensee Ex. 25.

<sup>[31]</sup> *Id.* at 2.

- [\[32\]](#) *Id.*
- [\[33\]](#) Licensee Ex. 26.
- [\[34\]](#) Dept. Ex. 13.
- [\[35\]](#) Licensee Ex. 12.
- [\[36\]](#) Dept. Ex. 14.
- [\[37\]](#) Dept. Ex. 15.
- [\[38\]](#) Dept. Ex. 15.
- [\[39\]](#) Licensee Ex. 1.
- [\[40\]](#) Minn. Stat. §§ 245A.07, subd. 1; 245A.08; 14.50 (2002).
- [\[41\]](#) Minn. Stat. § 245A.08, subd. 3.
- [\[42\]](#) Minn. R. 9502.0315, subp. 29a.
- [\[43\]](#) Minn. R. 9502.0375, subp. 2.D.
- [\[44\]](#) Minn. R. 9502.0415, subp. 1; Minn. R. 9502.0425, subp. 1.
- [\[45\]](#) Minn. R. 9502.0425, subp. 1.
- [\[46\]](#) Licensee Ex. 12.